TOGETHER FOR KIDS & FAMILIES
Indicator Profiles

 # 1

INDICATOR: Ratio of (a) licensed physicians and (b) licensed dentists to the number of children (0-8) by state and county.

DEFINITION: **Numerator-** a) Number of licensed physicians and b) number of licensed dentists by county and state.
Denominator- (For a and for b) Total number of Nebraska children (0-8) by county and by state.

TFKF OBJECTIVE: **MEDICAL HOME OUTCOME:** All Nebraska children have access to a dental/medical home, and receive high quality health services.

DATA SOURCES/ DATA ISSUES: **Numerator-** HHSS Licensing Data (Office of Rural Health).
Denominator- U.S Census Bureau estimates.

SIGNIFICANCE/ FOCUS/RATIONALE:

This indicator focuses on both accessibility to, and quality of healthcare for Nebraska children. It is more difficult to establish a Medical Home if distribution of practitioners is disparate. Regional data could be useful in recruiting physicians or establishing clinics or other innovative ways to see that children have access to medical services.

CITATION:

DeRigne, L., Porterfield, S. (2010). Employment change and the role of the medical home for married and single-mother families with children with special health care needs. *Social Science & Medicine,* 70(4), 631-641.

Farrigan, T. (2009). Children's Health Insurance and National Health Policy. *Choices: The Magazine of Food, Farm & Resource Issues,* 24(4), 20-24.

Voigt-Geurink, K. (2008). Dental Hygienists' Role in Establishing Dental Homes for Head Start Children. *Access,* 22(2), 30-34.

 # 2

INDICATOR: Percent of Nebraska Kids Connection eligible children who received an EPSDT exam during most recent state fiscal year. (EPSDT= Early and Periodic Screening, Diagnosis and Treatment.)

DEFINITION: **Numerator-** Number of Nebraska children eligible for Kids Connection who received an EPSDT exam in most recent fiscal year.
Denominator- Total number of Nebraska children eligible for Kids Connection.

TFKF OBJECTIVE: MEDICAL HOME OUTCOME: All Nebraska children have access to a dental/medical home, and receive high quality health services.

DATA SOURCES/ DATA ISSUES: **Numerator-** HHSS Medicaid Form CMS-416 Annual EPSDT Participation Report.
Denominator- HHSS Medicaid.

SIGNIFICANCE/ FOCUS/RATIONALE:
The Focus of this indicator is the quality of health care received by Nebraska children. Children who receive routine preventative exams are also more likely to receive earlier diagnosis and treatment of a number of disorders. Analysis of these data by region of the state, race, ethnicity and such factors as fee-for-service vs. managed care could provide important information for future policy direction or focusing on physician awareness and participation in EPSDT exams.

CITATION:

Hull, P., Husaini, B., et.al. (2008). EPSDT Preventive Services in a Low-Income Pediatric Population: Impact of a Nursing Protocol. *Clinical Pediatrics,* 47(2), 137-142.

Nathanson, D., Lee, G., Tzioumi, D. (2009). Children in out-of-home care: Does routine health screening improve outcomes? *Journal of Pediatrics & Child Health,* 45(11), 665-669.

 # 3

INDICATOR: Percent of Nebraska children (19 –35) months who have received the 4:3:1:3:3:1 immunization series.

DEFINITION: **Numerator-** Number of Nebraska children (19 –35) months who have received their 4:3:1:3:3:1 immunization series.
Denominator- Number of children in Nebraska aged 19-35 months.

TFKF OBJECTIVE: **MEDICAL HOME OUTCOME:** All Nebraska children have access to a dental/medical home, and receive high quality health services.

DATA SOURCES/ DATA ISSUES: **Numerator-** The National Immunization Survey (National Center for Health Statistics).
Denominator- U.S. Census Bureau estimates.

SIGNIFICANCE/ FOCUS/RATIONALE:

The focus of this indicator is access to quality preventive health care. It is significant because, in addition to knowing how thoroughly Nebraska children are being immunized, we know that when children receive immunizations, they are more likely to be receiving other health care services as well.

CITATION:

Kurilo, M., Pabst, L., Weinbaum, C. (2010). Hepatitis A Vaccination Coverage Among U.S. Children Aged 12-23 Months -- Immunization Information System Sentinel Sites, 2006-2009. *MMWR: Morbidity & Mortality Weekly Report,* 59(25), 776-779.

Wooten, K., Kolasa, M., Singleton, J., Shefer, A. (2010). National, State, and Local Area Vaccination Coverage Among Children Aged 19-35 Months -- United States, 2009. *MMWR: Morbidity & Mortality Weekly Report,* 59(36), 1171-1177.

Zhao, Z., Smith, P., Luman, E. (2009). Trends in early childhood vaccination coverage: Progress towards US Healthy People 2010 goals. *Vaccine,* 27(36), 5008-5012.

 # 4

INDICATOR: Percent of Nebraska children (0-8) who do not have health insurance.

DEFINITION: **Numerator-** Number of children (0-18) in Nebraska who do not have insurance coverage.
Denominator- Total number of Children (0 -18) in Nebraska.

TFKF OBJECTIVE: **MEDICAL HOME OUTCOME:** All Nebraska children have access to a dental/medical home, and receive high quality health services.

DATA SOURCES/ DATA ISSUES: **Numerator-** U.S. Census Bureau – Current Population Survey; Annual Social & Economic Supplement.

Denominator- U.S**.** Census Bureau estimates.

SIGNIFICANCE/ FOCUS/RATIONALE:
The focus of this indicator is access to quality health care. Children who have health insurance coverage, are more apt to have a Medical Home and, thus, receive more timely and comprehensive health care.

CITATION:

DeRigne, L., Porterfield, S., Metz, S. (2009). The Influence of Health Insurance on Parent's Reports of Children's Unmet Mental Health Needs. *Maternal & Child Health Journal,* 13(2), 176-186.

Kogan, M., Newacheck, P., et.al. (2010). Underinsurance among Children in the United States. *New England Journal of Medicine,* 363(9), 841-851.

Stevens, G., Seid, M., Pickering, T., Kai-Ya, T. (2010). National Disparities in the Quality of a Medical Home for Children. Maternal & Child Health Journal, 14(4), 580-589.

 # 5

INDICATOR: Prevalence of new mothers who experienced maternal depression related to their most recent pregnancy. (calendar year)

DEFINITION: **Numerator-** Estimated number of new mothers who experienced depression during or following their most recent pregnancy. (Based on their response to the question, "At any time during your most recent pregnancy, did you seek help for depression from a doctor, nurse or other health care worker?"

Denominator- Total number of live births to Nebraska residents during the applicable calendar year.

TFKF OBJECTIVE: **MENTAL HEALTH OUTCOME:** The early childhood social, emotional and behavioral health needs of Nebraska's children are met.

DATA SOURCES/ DATA ISSUES: **Numerator-** PRAMS (Pregnancy Risk Assessment Management System) data.

Denominator- Nebraska Vital Statistics.

SIGNIFICANCE/ FOCUS/RATIONALE:

The focus of this indicator is the effect of the mother's emotional condition on infant development. Research indicates that 10 – 15% of mothers experience a postpartum depression severe enough to interfere with her ability to care for herself and her baby. This indicator assumes there is a correlation between a mother's social-emotional-behavioral health and that of her young child. The incidence of postpartum depression therefore becomes a public health issue.

CITATION:

Goodman, J. (2008). Influences of maternal postpartum depression on fathers and on father–infant interaction. *Infant Mental Health Journal,* 29(6), 624-643.

Paulson, J., Keefe, H., Leiferman, J. (2009). Early parental depression and child language development. *Journal of Child Psychology & Psychiatry,* 50(3), 254-262.

 # 6

INDICATOR: Percent of Kids Connection eligible Nebraska children receiving mental health treatment.

DEFINITION: **Numerator-** The number of Medicaid/CHIP eligible children, ages 0-8, for whom a claim is paid for a mental health disorder.
Denominator - Total number of Nebraska Medicaid/CHIP cases of children, ages 0-8.

TFKF OBJECTIVE: The early childhood social, emotional and behavioral health needs of Nebraska's children are met.

DATA SOURCES/

DATA ISSUES: **Numerator-** HHS Medicaid Management Information System (MMIS).

Denominator- Medicaid / CHIP data; from HHSS Financial and Program Analysis unit.

SIGNIFICANCE/

FOCUS/RATIONALE: *This indicator focuses on the identification of social-emotional-behavioral disorders among Nebraska children and access to treatment for those disorders.*
While this won't grant a comprehensive picture of mental health services for all Nebraska children, an ongoing review of Medicaid and CHIP eligible children will indicate a level of such services provided. Further analysis by such factors as
urban / rural, race and ethnicity could offer information about problem identification and service availability.

CITATION:

Boothroyd, R., Armstrong, M. (2010). An Examination of the Psychometric Properties of the Pediatric Symptom Checklist With Children Enrolled in Medicaid. *Journal of Emotional & Behavioral Disorders,* 18(2), 113-126.

Pecora, P., Jensen, P., Romanelli, L., Jackson, L., Ortiz, A. (2009). Mental Health Services for Children Placed in Foster Care: An Overview of Current Challenges. *Child Welfare,* 88(1), 5-26.

Wells, R., Hillemeier, M., Bai, Y., Belue, R. (2009). Health service access across racial/ethnic groups of children in the child welfare system. *Child Abuse & Neglect,* 33(5), 282-292.

 # 7

INDICATOR: Percent of licensed child care providers receiving child care subsidy.

DEFINITION: **Numerator-** Number of licensed providers with child care subsidy contracts.
Denominator- Total number of licensed providers.

TFKF OBJECTIVE: **EARLY CARE AND EDUCATION OUTCOME:** Early care and education in Nebraska is high quality, developmentally appropriate and accessible to all children.

DATA SOURCES/ **Numerator-** HHSS Child Care Subsidy program data tracking system.
DATA ISSUES: **Denominator-** HHSS Child Care Licensing data management system.

SIGNIFICANCE/ FOCUS/RATIONALE:

While not all families eligible for child care subsidies will receive them, knowing the proportion of licensed providers who receive subsidy payments will help determine access to child-care services for those families that are economically disadvantaged.
Analysis of data by region or locale may provide information for further service development.

CITATION:

Magnuson, K., Shager, H. (2010). Early education: Progress and promise for children from low-income families. *Children & Youth Services Review,* 32(9), 1186-1198.

Myungkook, J. (2008). The Impact of Availability and Generosity of Subsidized Child Care on Low-Income Mothers' Hours of Work. *Journal of Policy Practice,* 7(4), 298-313.

#8

INDICATOR: Number of licensed child care slots per 1000 Nebraska children ages birth through age 8.

DEFINITION: **Numerator -** Number of licensed child care "slots" in Nebraska.
Denominator- Total number of Nebraska children between the ages of birth to their 9th birthday.

TFKF OBJECTIVE: **EARLY CARE AND EDUCATION OUTCOME:** Early care and education in Nebraska is high quality, developmentally appropriate and **accessible** to all children.

DATA SOURCES/ DATA ISSUES: **Numerator-** HHSS Regulation and Licensure, Child Care License data.
Denominator – U.S. Census estimates. Total # of children ages birth through age 8 living in Nebraska.

SIGNIFICANCE/FOCUS RATIONALE:

This is designed to be an indicator of accessibility to licensed child care services for those families who need care. Where there are fewer slots per child, it is more likely that a child will be placed in an unregulated or unlicensed program that may not be the best placement for the child nor desired by the parent.
Additional analysis of locations, age cohorts and/or license types (centers, homes I & II, pre-schools) could be useful for program planning, targeting incentives, etc.

CITATION:

Dearing, E., McCartney K., Taylor, B. (2009). Does Higher Quality Early Child Care Promote Low-Income Children's Math and Reading Achievement in Middle Childhood? *Child Development,* 80(5), 1329-1349.

Groeneveld, M., Vermeer, H., Van IJzendoorn, M., Linting, M. (2010). Children's wellbeing and cortisol levels in home-based and center-based childcare. *Early Childhood Research Quarterly,* 25(4), 502-514.

Pluess, M., Birkbeck, J. (2010). Differential Susceptibility to Parenting and Quality Child Care. *Developmental Psychology,* 46(2), 379-390.

Raikes, H.H, Wilcox, B., Peterson, C., Hegland, S., Atwater, J., Summers, J.A., et al. (2003). *Child care quality and workforce participation in four Midwestern states.* Lincoln, NE: The Center on Children, Families and the Law.

 # 9

INDICATOR: Prevalence of new mothers who participated in parenting classes during their most recent pregnancy. (calendar year)

DEFINITION: **Numerator-** Estimated number of new mothers who participated in a parenting class during their last pregnancy.
Denominator- The total number of live births to Nebraska residents during the most recent calendar year.

TFKF OBJECTIVE: **PARENT EDUCATION OUTCOME:** Nebraska families support their children's optimal development by providing safe, healthy and nurturing environments.

DATA SOURCES/ DATA ISSUES: **Numerator-** PRAMS (Pregnancy Risk Assessment Management System) data.
Denominator- Nebraska Vital Statistics.

SIGNIFICANCE/ FOCUS/RATIONALE:

The focus of this indicator is participation by Nebraska parents in parenting classes. This is based on the assumption that participation in parenting classes indicates that those parents are more likely to "support their children's healthy development." This may well be a valid assumption, but it should be noted that this measures a process, and is not intended as a direct measure of how effectively Nebraska parents support their children's development.

CITATION:

Scott, S., O'Connor, T., et.al. (2010). Impact of a parenting program in a high-risk, multi-ethnic community: the PALS trial Stephen Scott et al. Impact of a parenting program in a high-risk, multi-ethnic community. *Journal of Child Psychology & Psychiatry,* 51(12), 1331-1341.

Wilson, K., Gonzalez, P., Romero, T., Henry, K., Cerbana, C. (2010). The Effectiveness of Parent Education for Incarcerated Parents: An Evaluation of Parenting from Prison. *Journal of Correctional Education,* 61(2), 114-132.

#10

INDICATOR: Percent of Nebraska children (0-8) whose family incomes are less than 100% of the federal poverty thresholds.

DEFINITION: **Numerator-** Number of Nebraska children (0 – 8) whose family incomes are less than 100% of federal poverty thresholds.
Denominator- Number of Nebraska resident children, ages 0 – 8.

TFKF OBJECTIVE: **FAMILY SUPPORT OUTCOME:** Nebraska families support their children's optimal development by providing safe, healthy and nurturing environments.

DATA SOURCES/ DATA ISSUES: **Numerator-** US Census estimates; Current Population Survey; [http://www.census.gov/hhes/www/cpstc/cps-table_creator.html]
Denominator- US Census Bureau estimates.

SIGNIFICANCE/ FOCUS/RATIONALE:

Children raised in poverty are more likely to experience poor health, diminished personal and social development and have decreased educational attainment and earning potential.

CITATION:

Bringewatt, E., Gershoff, E. (2010). Falling through the cracks: Gaps and barriers in the mental health system for America's disadvantaged children. Children & Youth Services Review, 32(10), 1291-1299.

Fox, R., Holtz, C. (2009). Treatment Outcomes for Toddlers with Behaviour Problems from Families in Poverty**.** *Child & Adolescent Mental Health,* 14(4), 183-189.

Larson, K., Halfon, N. (2010). Family Income Gradients in the Health and Health Care Access of US Children. *Maternal & Child Health Journal,* 14(3), 332-342.

 # 11

INDICATOR: Rate of substantiated child protective services cases of Nebraska children
(Birth – 8 years), per 1000.

DEFINITION: **Numerator:** Number of substantiated cases of child abuse or neglect of children (birth – 8 years) in Nebraska.
Denominator: Total number of children (birth – 8 years) in Nebraska.

TFKF OBJECTIVE: **FAMILY SUPPORT OUTCOME:** Nebraska families support their children's optimal development by providing safe, healthy and nurturing environments.

DATA SOURCES/ **Numerator:** Nebraska Health & Human Services Child Abuse & Neglect
DATA ISSUES: Annual Report.
Denominator: U.S. Census Bureau estimates.

SIGNIFICANCE/ FOCUS/RATIONALE:

According to the *2010 KIDS Count Report,* the number of substantiated cases of child abuse/neglect in Nebraska has increased from 18% in 2009 to 26.3% in 2010 (535 cases).Violence can disrupt growth and development, lower self-esteem, perpetuate a cycle of violence and cause or exacerbate mental health problems. Consideration of these findings in conjunction with findings of other Together for Kids & Families Indicators may provide clues about needed family supports in Nebraska. [*Voices for Children in Nebraska, (copyright) 2010 Kids Count in Nebraska Report*, January 2011]

CITATION:

Currie, J., Widom, C. (2010). Long-Term Consequences of Child Abuse and Neglect on Adult Economic Well-Being. *Child Maltreatment,* 15(2), 111-120.

Greenfield, E. (2010). Child abuse as a life-course social determinant of adult health. *Maturitas,* 66(1), 51-55.

Wilson, D. (2010). Health Consequences of Childhood Sexual Abuse. *Perspectives in Psychiatric Care,* 46(1), 56-64.

#12

INDICATOR: Number of Nebraska children (1 – 8 years) who die of an unintentional injury, per 100,000 children.

DEFINITION: **Numerator:** Number of Nebraska resident children (1– 8 years) who died from unintentional injuries during the calendar year.
Denominator: Total number of children (1 – 8 years) in Nebraska.

TFKF OBJECTIVE: **FAMILY SUPPORT OUTCOME:** Nebraska families support their children's optimal development by providing safe, healthy and nurturing environments.

DATA SOURCES/ DATA ISSUES: **Numerator:** Nebraska Health & Human Services System Child Death Review Team.
Denominator: U.S. Census Bureau estimates.

SIGNIFICANCE/ FOCUS/RATIONALE:

According to Nebraska Vital Statistics & Hospital Discharge data, unintentional injuries are the leading cause of death and hospitalizations among children 1-8. Unintentional injuries are preventable. They may lead to premature death, lifelong disabilities, and create a financial burden on our health care system in direct medical care and rehabilitation costs. Findings from this indicator could help identify any supports that could be provided to families with the aim of reducing unintentional injuries.

CITATION:

Hong, J., Lee, B., Ha, E., Park, H. (2010). Parental socioeconomic status and unintentional injury deaths in early childhood: Consideration of injury mechanisms, age at death, and gender. *Accident Analysis & Prevention,* 42(1), 313-319.

Morrongiello, B., Schell, S., Schmidt, S. (2010). "Please keep an eye on your younger sister": sibling supervision and young children's risk of unintentional injury. *Injury Prevention,* 16(6), 398-402.

Schnitzer, P., Ewigman, B. (2008). Household Composition and Fatal Unintentional Injuries Related to Child Maltreatment. *Journal of Nursing Scholarship,* 40(1), 91-97.

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